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No. 93-77

IN THE
Supreme Court of the United States
OCTOBER TERM, 1993

LINDA RANDOL and BRUCE RANDOL, JR.,
Petitioners,

v.

MID-WEST NATIONAL LIFE INSURANCE COMPANY OF TENNESSEE,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

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BRIEF AMICUS CURIAE OF THE AMERICAN COUNCIL OF LIFE INSURANCE IN OPPOSITION TO THE PETITION FOR CERTIORARI

Of Counsel:
RICHARD E. BARNSBACK
PHILLIP E. STANO
AMERICAN COUNCIL OF LIFE INSURANCE
1001 Pennsylvania Ave., N.W.
Washington, D.C. 20004-2559
(202) 624-2183

ERWIN N. GRISWOLD
PATRICIA A. DUNN
(Counsel of Record)
SHELBY J. HOOVER
LAURIE F. CALDER
JONES, DAY, REAVIS & POGUE
1450 G Street, N.W.
Washington, D.C. 20005-2088
(202) 879-3939
Counsel for Amicus Curiae The American Council of Life Insurance

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QUESTION PRESENTED

Whether an employer that, for the purpose of helping its employees obtain health insurance coverage, establishes a premium payment system for, and contributes to the cost of, an insurance policy for its employees "establishes or maintains" an "employee welfare benefit plan" within the meaning of the Employee Retirement Income Security Act of 1974.

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BRIEF AMICUS CURIAE OF THE AMERICAN COUNCIL OF LIFE INSURANCE IN OPPOSITION TO THE PETITION FOR CERTIORARI

INTERESTS OF THE AMICUS [1]

The American Council of Life Insurance ("ACLI") submits this brief on behalf of respondent Mid-West National Life Insurance Company of Tennessee. The ACLI is the largest life insurance trade association in the United States, representing the interests of 616 member life insurance companies. The ACLI's members currently hold 95 percent of the life insurance in force in legal reserve life insurance companies in the United States. These members often sell insurance to employers who choose to

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[1] Counsel for all parties have consented to the filing of this amicus brief. Amicus has filed those consents with the Clerk of this Court pursuant to Rule 37.2 of the Rules of this Court.

establish their employee welfare benefit plans through the purchase of insurance.

The ACLI files this brief to provide its unique perspective, based on its broad-based constituency, concerning why the Court should not grant certiorari review in this case. The issue presented in this case—whether an employer's contributions to the cost of an insurance policy for employees, coupled with its establishment of a premium payment system, "establishes or maintains" an "employee welfare benefit plan" under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 (1988 & Supp. III 1991) ("ERISA"), —is thus vitally important to the ACLI's members, but correctly decided by the court below. In other cases before the Court involving ERISA questions that affect its members, the ACLI has participated as an amicus. *See, e.g., Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985).

STATEMENT OF THE CASE

This case concerns the application of the Employee Retirement Income Security Act of 1974, *as amended* ("ERISA"), to an employee welfare benefit arrangement funded, in part, by employer contributions to the cost of an insurance policy purchased from Mid-West National Life Insurance Company of Tennessee ("Mid-West"). Petitioners Bruce and Linda Randol, respectively an employee of Ed's Tire Store, Inc. (the "employer") and his spouse, contend that this arrangement does not constitute an "employee welfare benefit plan" under ERISA and, accordingly, that ERISA does not preempt the state law claims in their complaint. The Eleventh Circuit disagreed. Consistent with the other courts of appeals that have addressed the issue squarely, the Eleventh Circuit held that the employer's welfare benefit arrangement constitutes an ERISA plan.

1. The employer, a small tire franchise in Mobile, Alabama, offered no insurance to its three employees prior to March 1988 (Pet. App. 2a). At that time, while the Randols were apparently seeking medical insurance coverage, an agent of Mid-West met with Mr. Randol on the employer's premises, with the employer's permission, concerning his insurance options (*id.* at 2a-3a). Because of its employees' interest in obtaining insurance from Mid-West, the employer agreed to assist them in the purchase of this insurance. To this end, the employer: (1) wrote a check to Mid-West on its corporate account to cover the initial premium payment for Randol and its other interested employee (*id.* at 3a); (2) agreed to contribute $75 each month toward the monthly premium payments for each of its covered employees (*id.*); (3) agreed to collect the balance of the premium from each covered employee through weekly payroll deductions (*id.*); and (4) signed a bank draft authorization form allowing Mid-West to withdraw the monthly premiums from its account (Pet. Br. 4). The employer did the foregoing "in order to facilitate his employees' obtaining health coverage" (Pet. App. 9a).

Mid-West insured and administered the insurance program, which was considered "group" insurance coverage (Pet. App. 3a). The Randols, therefore, submitted their claims for medical benefits arising from complications with Mrs. Randol's pregnancy to Mid-West. When Mid-West denied the Randols' claim for medical benefits, they sued Mid-West in state court, claiming that this denial constituted a breach of contract, a bad-faith denial of a claim for benefits, and fraud (*id.* at 1a).

2. On July 22, 1991, Mid-West removed this action to federal district court (Pet. App. 1a). On October 11, 1991, the district court dismissed petitioners' state common law tort and contract claims on the grounds that the insurance policy was an "employee welfare benefit plan" within the meaning of ERISA and, therefore, ERISA preempted petitioners' state claims (*id.* at 13a).

The Eleventh Circuit affirmed the district court's decision on April 12, 1993 (Pet. App. 1a, 11a). First, the court held that the employer's insurance arrangement did not fall within the scope of the Department of Labor's safe harbor regulation, which identifies practices that, in the opinion of the Department, do not amount to "establishing" or "maintaining" an ERISA "plan, fund, or program" (*id.* at 6a; see discussion *infra* at 6-7). Next, after noting that it is "unsettled . . . whether the safe harbor regulations' description of group insurance plans excluded from [ERISA] is exhaustive" (*id.* at 6a n.3), the court held that the employer's insurance arrangement was an ERISA § 3(1) "plan," as the Eleventh Circuit defined that term in *Donovan v. Dillingham,* 688 F.2d 1367, 1373 (11th Cir. 1982) (en banc) (*id.* at 7a-8a). Finally, the court held that the employer "maintained" the plan within the meaning of ERISA by "wr[iting] the first check purchasing the policies, establish[ing] a system whereby the premiums would be paid monthly by means of a bank draft on the corporate account, contribut[ing] $75 per employee per month toward the premiums, and collect[ing] from the employees the balance of the premiums through a withholding system" (*id.* at 8a-9a). The court further noted that "the employer did the foregoing in order to facilitate his employees' obtaining health coverage" (*id.* at 9a).

ARGUMENT

In asking this Court to grant review, petitioners seek to generate decisional conflicts where none exist. The Eleventh Circuit correctly held that the insurance arrangement in this case—where the employer, with the intent of helping its employees obtain health insurance coverage, established a premium payment system for, and contributed to the cost of, a health insurance policy for its employees—constituted an ERISA employee welfare benefit plan. The court recognized that ERISA fully contemplates that employers (and, in particular, small employers) will often establish employee welfare benefit

plans through insurance arrangements and, in doing so, will delegate most of the administrative duties relating to those plans to insurers or outside administrators.

When reviewing this type of insurance arrangement, this Court and the courts of appeals have similarly recognized that employers can—and often do—play limited, yet meaningful, roles in these plans, without removing them from ERISA's expansive reach. Because the Eleventh Circuit's decision is entirely consistent with this uniform understanding, as well as with ERISA's language and underlying policies, there is no good reason for the Court to review it.

I. THE COURT NEED NOT REVIEW THE ELEVENTH CIRCUIT'S DECISION THAT THE EMPLOYER'S INSURANCE ARRANGEMENT IS AN EMPLOYEE WELFARE BENEFIT PLAN BECAUSE IT IS CONSISTENT WITH THE DECISIONS OF OTHER COURTS OF APPEALS AND THIS COURT'S PRECEDENT

Section 3(1) of ERISA, 29 U.S.C. § 1002(1), states that an "employee welfare benefit plan" is:

> any plan, fund, or program which was . . . *established or maintained by an employer* . . . to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical . . . benefits . . .

(emphasis added). The Eleventh Circuit held that the employer in this case satisfied Section 3(1)'s "maintenance" requirement by: (1) writing a check to purchase medical insurance policies from Mid-West; (2) establishing a system whereby the premiums would be paid monthy by means of a bank draft on the corporate account; (3) contributing $75 per employee per month toward the premiums; (4) collecting from the employees the balance of the premiums through a withholding system; and (5) doing all of these things to "facilitate his employees' ob-

taining health coverage" (Pet. App. 9a). This holding and reasoning are fully consistent with the decisions of other courts of appeals and with this Court's precedent, rendering review in this Court unnecessary.

A. The Eleventh Circuit's Analysis of ERISA § 3(1)'s "Established Or Maintained" Requirement Is Fully Consistent With The Analyses Of Other Courts of Appeals

Contrary to petitioners' assertion (Pet. Br. 22-27), there is no meaningful distinction between the Eleventh Circuit's analysis of ERISA's "maintenance" requirement and the analyses of the Fifth, Seventh, and Tenth Circuits. Like the court below, the Fifth, Seventh, and Tenth Circuits all conduct the essential inquiry into the degree of employer involvement in the operation of the plan before subjecting the plan to ERISA regulation.

1. That there is no hard and fast rule for determining the minimum level of employer involvement that will subject an insurance arrangement to ERISA hardly rises to the level of a conflict. This area is not without meaningful guidance. At one end of the spectrum, the Department of Labor has promulgated a regulation that provides a "safe harbor" for insured benefit programs where employer involvement is so minimal that the requisite "establishment or maintenance" activity required for ERISA coverage is absent. *See* Preamble to the Proposed Regulation at 29 C.F.R. § 2510.3-1(j), 40 Fed. Reg. 24,643 (1975). To qualify for this safe harbor:

(1) The employer can make no contributions;

(2) Participation in the program must be completely voluntary for employees;

(3) The employer's sole functions under the program may be to permit the insurer to publicize the program to employees, to collect premiums through payroll deductions and to remit them to the insurer, without taking any action that

could be considered an "endorsement" of the program; and

(4) The employer may not receive any consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation for administrative services actually rendered in connection with payroll deductions.

29 C.F.R. § 2510.3-1(j) (1992). This safe harbor regulation thus ensures that, when an employer's involvement in an insurance arrangement amounts to no more than that of a "passive bystander," the arrangement will not fall within ERISA's regulatory scope.

Beyond this "passive bystander" rule, the courts have uniformly recognized that more meaningful employer involvement will trigger ERISA coverage. They also uniformly recognize that such involvement may take many forms. *See, e.g., Hansen v. Continental Ins. Co.*, 940 F.2d 971, 978 (5th Cir. 1991) (employer involvement may take the form of "collection of premiums, administration of the policy, *or* submission of claims" (emphasis added)); *Peckham v. Gem State Mutual of Utah*, 964 F.2d 1043, 1049 (10th Cir. 1992) (employer "established or maintained" an ERISA plan because it "joined [a multi-employer trust] in order to obtain insurance for its employees, purchased basic insurance . . . for its employees, and listed insurance in its company manual as an employment benefit"); *Brundage-Peterson v. Compcare Health Serv. Ins. Corp.*, 877 F.2d 509, 511 (7th Cir. 1989) (employer's contract with an insurance company to insure employees, establishment of a single eligibility requirement for that insurance coverage, and contribution of the workers' share of the premiums brought the insurance arrangement under ERISA).

These courts also make clear that the employer's involvement in the plan may well be quite minimal—and need not include control over the eligibility for coverage

or participation in processing claims for benefits. Delegation of these functions to an insurer or outside agent is perfectly consistent with the language and purposes of ERISA. *See, e.g., Peckham*, 964 F.2d at 1048 n.9; *Brundage-Peterson*, 877 F.2d at 511; *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 243 (5th Cir. 1990).[2]

2. Petitioners also are mistaken in invoking *Taggart Corp. v. Life & Health Benefits Administration, Inc.*, 617 F.2d 1208 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030 (1981), as a source of discord between the Fifth and the Eleventh Circuits. In *Taggart*, the Fifth Circuit held that an employer's "bare purchase[] of health insurance" through a Multiple Employer Trust did not establish an ERISA plan under the facts and circumstances of that case. *Id.* at 1211. The court below made clear that the facts in this case "differ significantly from those in *Taggart*" (Pet. App. 10a): unlike the employer in *Taggart*, the employer here "established a system for withholding premiums from employee wages and paying them directly to the carrier, . . . contributed $75 per employee toward the monthly premium and did so for the purpose of helping the employees obtain health insurance coverage" (*id.*).

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[2] *MDPhysicians & Assocs. v. State Bd. of Ins.*, 957 F.2d 178, 185 (5th Cir.), *cert. denied*, 113 S. Ct. 179 (1992), upon which petitioners also rely (Pet. Br. 19), is not to the contrary. In *MDPhysicians*, the court determined whether, by establishing a multiple employer welfare arrangement ("MEWA") within the meaning of ERISA § 3(40), the manager of the MEWA established a single ERISA-covered plan. The court thus examined the question whether the manager was acting on behalf of a group of related employers, which would make the manager an "employer" within the meaning of ERISA § 3(5) and the MEWA a single ERISA-covered plan. The court expressly stated that its decision did not address the question whether any of the subscribing employers themselves established ERISA-covered plans for their employees by subscribing to the MEWA. *MDPhysicians*, 957 F.2d at 182 n.4. *MD Physicians* thus has no relevance to this case.

In any event, in other contexts, both the Fifth Circuit —even after *Taggart*—and the Eleventh Circuit have agreed that the purchase of insurance, without more, may not conclusively establish a plan, fund, or program, but that " 'the purchase of a policy or multiple policies covering a class of employees offers *substantial evidence* that a plan, fund, or program has been established.' " *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 242 (5th Cir. 1990) (quoting *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982) (en banc) (emphasis added)). *See also Wickman v. Northwestern Nat'l Ins. Co.*, 908 F.2d 1077, 1083 (1st Cir.), *cert. denied*, 498 U.S. 1013 (1990) (same). *Taggart*, then, is not a source of a circuit court split. Even had there been such a conflict, these courts themselves have seemingly resolved it.

3. Petitioners' effort to create a conflict with other circuits, pointing to a heightened "intent" requirement that the court below supposedly did not apply, is similarly misplaced. The Eleventh Circuit twice made clear that the employer participated in the purchase of the insurance policies and the continued operation of the plan "*in order to* facilitate his employees' obtaining health coverage" (Pet. App. 9a (emphasis added)); *see also id.* at 10a. To the extent that the cases upon which petitioners rely might be regarded as purporting to establish an intent requirement, the Eleventh Circuit's analysis more than satisfies it. *See Hansen v. Continental Ins. Co.*, 940 F.2d 971, 978 (5th Cir. 1991) (the evidence must show that the employer had an " 'intent to provide its employees with a welfare benefit program through the purchase and maintenance of [the] group insurance policy' " (citation omitted)); *Ed Miniat, Inc. v. Globe Life Ins. Group*, 805 F.2d 732, 741 (7th Cir. 1986), *cert. denied*, 482 U.S. 915 (1987) ("In the case before us the corporation has, via written agreement, established its intent potentially to provide benefits to all salaried em-

ployees.").[3] Indeed, in *Wickman v. Northwestern Nat'l Life Ins. Co.*, 908 F.2d at 1083, the First Circuit relied on the Eleventh Circuit's analysis in *Donovan v. Dillingham*, 688 F.2d at 1374-75, as an example of how its stated intent requirement works in practice. Petitioners thus have failed to show how the Eleventh Circuit's application of the so-called "intent" requirement meaningfully deviates from the analysis of any of the other courts of appeals.[4]

4. In all events, petitioners' suggestion that a circuit court conflict exists fails to find any support in the words or actions of the very courts on which petitioners seek to rely. Those courts, which supposedly have "implicitly or explicitly rejected the Eleventh Circuit's test" (Pet. Br.

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[3] *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 493 (9th Cir. 1988) (per curiam), *cert. denied*, 492 U.S. 906 (1989), upon which petitioners rely, does not purport to establish an "intent" requirement. In that case, the Ninth Circuit simply noted that evidence existed showing that the plan administrator intended to create an ERISA plan.

[4] Petitioners suggest (Pet. Br. 6), without case law support, that a "plan" does not fall within the purview of ERISA unless an employer has an intent to establish an ERISA-covered plan or satisfies all ERISA requirements. The reason that petitioners find no support for this remarkable proposition is clear: such a requirement would give persons establishing or maintaining such arrangements the ability to circumvent ERISA by either expressly denying any intent to establish a plan or merely failing to perform certain duties required under ERISA. *See Donovan v. Dillingham*, 688 F.2d 1367, 1372 (11th Cir. 1982) (en banc); *see also Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1503 (9th Cir. 1985); *Dependahl v. Falstaff Brewing Corp.*, 491 F. Supp. 1188, 1195 (E.D. Mo. 1980), *aff'd in part and rev'd in part*, 653 F.2d 1208 (8th Cir.), *cert. denied*, 454 U.S. 968 and 454 U.S. 1084 (1981). The Eleventh Circuit thus decided correctly (and consistent with the decisions of other courts) that the fact that the employer here had no written plan, denied any intention of creating an ERISA-covered plan, complied with none of the reporting or disclosure requirements of ERISA, appointed no official plan administrator (separate from the insurer), and had no designated plan fiduciaries was irrelevant to the determination of ERISA plan status.

22), repeatedly invoke Eleventh Circuit precedent in support of their reasoning and conclusions. *See, e.g., Kidder v. H & B Marine, Inc.*, 932 F.2d 347, 353 (5th Cir. 1991) (per curiam); *Brundage-Peterson v. Compcare Health Serv. Ins.*, 877 F.2d 509, 511 (7th Cir. 1989); *Peckham v. Gem State Mutual of Utah*, 964 F.2d 1043, 1047 (10th Cir. 1992); *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 492 (9th Cir. 1988) (per curiam), *cert. denied*, 492 U.S. 906 (1989). And the courts do so without even hinting that they disagree with any part or parts of the Eleventh Circuit's approach.

Even more tellingly, the circuits that are in supposed conflict with the Eleventh Circuit have ruled that insurance arrangements with the same or even less employer involvement than the arrangement at issue here constitute "employee welfare benefit plans." *See, e.g., Roe v. General American Life Ins. Co.*, 712 F.2d 450, 451-52 (10th Cir. 1983) (plan existed where employer made life insurance available to its employees and contributed part of each employee's premium); *Memorial Hosp. Sys. v. Northbrook Ins. Co.*, 904 F.2d 236, 241 (5th Cir. 1990) ("Noffs established and maintained the plan by purchasing the policy and paying the premiums directly to Northbrook"); *Credit Managers Ass'n v. Kennesaw Life & Accident Ins. Co.*, 809 F.2d 617, 625 (9th Cir. 1987) ("Even if an employer does no more than arrange for a 'group-type insurance program,' it can establish an ERISA plan, unless it is a mere advertiser who makes no contributions on behalf of its employees"). These words and actions plainly contradict the notion that a meaningful conflict exists that this Court must resolve.

B. The Eleventh Circuit's Conclusion That The Employer's Insurance Arrangement Is Governed By ERISA Is Fully Consistent With The Decisions Of This Court.

Petitioners' contention that the decision below conflicts with past decisions of this Court is equally unfounded. As an initial matter, petitioners fail to mention *Metro-*

politan Life Insurance Co. v. Massachusetts, 471 U.S. 724 (1985), in which this Court made clear that insurance arrangements, like the arrangement in this case, generally are "employee welfare benefit plans." *See id.* at 739. Instead, petitioners cite *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), and *Massachusetts v. Morash*, 490 U.S. 107 (1989), neither of which even addresses the issue of how much employer involvement is necessary to bring an insurance arrangement under ERISA. Moreover, to the extent that *Fort Halifax* and *Morash* have any bearing on this case, they support the conclusion that the employer's insurance arrangement here is an ERISA "employee welfare benefit plan."

In *Fort Halifax*, the Court addressed the question whether a Maine statute that required employers to provide a one-time severance payment to employees in the event of a plant closing required an employer to establish or maintain an employee welfare benefit plan. In holding that the statute did not do so, the Court explained that a "plan," as opposed to a mere "benefit," "embodies a set of administrative practices vulnerable to the burden that would be imposed by a patchwork scheme of regulation." *Id.* at 11-12. Under this reasoning, the statute did not require employers to establish or maintain plans because "[t]he theoretical possibility of a one-time obligation in the future simply creates no need for an ongoing administrative program for processing claims and paying benefits." *Id.* at 12.

Like *Fort Halifax*, *Morash* focuses on the nature of the benefits provided, rather than on the employer's involvement in providing those benefits. The Court there considered whether a Massachusetts statute that required employers to pay a discharged employee for unused vacation time on the date of discharge required an employer to establish or maintain an employee welfare benefit plan. The Court held that the statute did not do so, reasoning that: "Because ordinary vacation benefits are typi-

cally fixed, due at known times, and do not depend on contingencies outside the employee's control, they present none of the risks that ERISA is intended to address." *Morash*, 490 U.S. at 115.

The insurance arrangement in this case easily meets the "plan" requirement set out in *Fort Halifax* and *Morash*. Providing medical benefits through Mid-West's insurance policy indisputably involves "a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements." *Fort Halifax*, 482 U.S. at 9. It also implicates the risks that ERISA was designed to address. Nothing in *Fort Halifax* or *Morash* states that some or all of these obligations or risks must be undertaken or borne by an employer, as opposed to an insurer-administrator. *See Brundage-Peterson*, 877 F.2d at 511 ("The contingent feature of a true welfare benefits plan, stressed in . . . *Massachusetts v. Morash*, [490 U.S. 107] (1989) is unaffected by the delegation of administration of the plan to an insurance company—a delegation in fact contemplated by statute").

The Eleventh Circuit's decision in this case thus is fully consistent with the decisions of other courts of appeals and this Court. The courts have given employers (both large and small) ample notice that, by administratively and financially helping their employees to obtain health insurance coverage, the employers may have to submit to ERISA regulation. No further guidance from this Court is necessary.

II. THE COURT NEED NOT REVIEW THE ELEVENTH CIRCUIT'S DECISION BECAUSE IT IS CONSISTENT WITH ERISA'S LANGUAGE AND UNDERLYING POLICIES

This Court's review of the Eleventh Circuit's decision is unnecessary for another reason. The decision below properly interprets ERISA's language and implements its underlying policies, both of which contemplate that employers often will establish employee welfare benefit plans through insurance arrangements like the arrangement at issue in this case.

In enacting ERISA, Congress clearly contemplated that insurers would play vital roles in both funding and administering employer-sponsored welfare benefit programs. ERISA § 3(1) defines an "employee welfare benefit plan" as "any plan, fund, or program which was . . . established or maintained by an employer . . . *through the purchase of insurance or otherwise*" (emphasis added). ERISA's terms also permit the delegation of administrative duties to third parties (such as insurers) without requiring the employer/sponsor to retain any particular duties under the plan (ERISA § 405(c)(1), 29 U.S.C. § 1105(c)(1)); indeed, ERISA's definition of "plan administrator" expressly states that the administrator may be someone other than the employer (ERISA § 3(16)(A), 29 U.S.C. § 1002(16)(A)). These terms and others sprinkled throughout ERISA [5] plainly reflect Congress's intent that

[5] *See, e.g.*, ERISA § 3(38), 29 U.S.C. § 1002(38) (defining the entities that may serve as investment managers for ERISA-covered plans, including any insurance company qualified to perform services under the laws of more than one state); ERISA § 401(b)(2), 29 U.S.C. § 1101(b)(2) (concerning the treatment of assets of an insurer that issues a guaranteed benefit policy to an ERISA-covered plan); ERISA § 403(b)(1) & (2), 29 U.S.C. § 1103(b)(1) & (2) (concerning the exemption from the general trust requirement for those assets of ERISA-covered plans that consist of insurance contracts or policies); ERISA § 408(b)(5), 29 U.S.C. § 1108(b)(5) (concerning the exemption from the prohibited transaction provi-

insurers and their insurance products would play an extensive role in ERISA-covered plans.

The Eleventh Circuit's decision that the employer's insurance arrangement is an employee welfare benefit plan also furthers ERISA's underlying policies. Indeed, to hold that the arrangement is not covered by ERISA would be tantamount to eliminating ERISA coverage for, and denying ERISA protections to, employees of many employers who select insurance as the funding mechanism for their employee benefit arrangements and who delegate the administration of those arrangements to an insurer. The employers who most frequently select insurance as the funding mechanism for their plans and who delegate the administration of those plans to insurers are not large employers; they are small employers, just like Mr. Randol's employer, for whom these types of insurance arrangements to provide benefits to their employees are, as a practical matter, essential.

In fact, a recent study showed that approximately 65 percent of the large employers in the United States self-fund their plans; in contrast, a majority of small employers fund their plans through insurance.[6] Small employers often turn to insurers to provide the benefits under, and to administer, their plans for obvious reasons. They typically do not have the staff, ability or time to

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sions for certain ERISA-covered plans that purchase insurance contracts or annuities from certain insurers); ERISA § 607(1), 29 U.S.C. § 1167(1) (concerning the definition of what constitutes a "group health plan" (an employee welfare benefit plan that provides medical care to participants directly or through insurance, reimbursement, or otherwise) for purposes of determining the applicability of the requirements of Part 6 of ERISA, which extend coverage under group health plans to plan participants after certain coverage terminating events).

[6] A. Foster Higgins & Co., 1988 Foster Higgins Health Care Benefits Survey 23 (1988). A large employer is defined in this study as one with 1,000 or more employees. A small employer is defined as one employing fewer than 1,000 employees.

administer their own plans. They need the broad spreading of risk that a group insurance policy can provide. And they need the efficiencies of scale that an insurer's established claims processing procedure and trained personnel offer.[7]

In enacting ERISA, Congress clearly understood that these special concerns faced small employers and that insurers would thus play a very significant role in ERISA-covered plans. The Eleventh Circuit properly refused to decide that a small employer may not be considered to have either "established or maintained" a "plan" under ERISA, even though it has (1) facilitated its employees' participation in an insured health benefit arrangement by promising them partial premium payments, (2) set up a premium payment procedure that includes giving authorization to the insurer to draw on the employer's corporate bank account for the premium payments, and (3) contributed a significant portion of each premium for payment for each participating employee.

A contrary decision would provide a blueprint to all small employers for precisely how to "opt out" of ERISA regulation. It would be bizarre, indeed, if a small employer could avoid ERISA's reach merely by stating that it does not "intend" to establish an ERISA plan when it contributes to the cost of insurance for its employees, by refusing to comply with any of ERISA's requirements, and by appointing an independent third party (whether an insurer or not) to administer its plan. The Eleventh Circuit properly rejected this unwarranted result and, in the process, rendered a decision entirely faithful to the statute, this Court's decisions, and the decisions of other courts of appeals.

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[7] *See* O. Mitchell & E. Andrews, *Scale Economics in Private Multi-Employer Pension Systems*, 34 Indus. & Lab. Rel. Rev. 522 (1981). This study shows that administrative expenses per participant are over ten times as high for plans with 100 participants as for those with 20,000 participants.

CONCLUSION

The petition for certiorari should be denied.

Respectfully submitted,

Of Counsel:
RICHARD E. BARNSBACK
PHILLIP E. STANO
AMERICAN COUNCIL OF
LIFE INSURANCE
1001 Pennsylvania Ave., N.W.
Washington, D.C. 20004-2559
(202) 624-2183

ERWIN N. GRISWOLD
PATRICIA A. DUNN
(Counsel of Record)
SHELBY J. HOOVER
LAURIE F. CALDER
JONES, DAY, REAVIS & POGUE
1450 G Street, N.W.
Washington, D.C. 20005-2088
(202) 879-3939
Counsel for Amicus Curiae
The American Council of
Life Insurance

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